Policy and Procedures Instruction (PPI): 4.09 Revised November 10, 1982

Title: Eligibility Criteria for State Funding of Abortion to Terminate Pregnancy as the Result of Rape or Incest, or Fetal Deformity

Effective: November 15, 1982
Expires: When Superseded (Updated 6/99)

I. **Purpose:** To promulgate the eligibility criteria and administrative procedures for obtaining state funding to pay for certain abortions to terminate pregnancies that are the result of rape or incest, or which may result in the birth of an infant with a gross and totally incapacitating physical abnormality or mental deficiency.

II. **Background:** The 1982 Regular Session of the General Assembly amended the Code of Virginia by adding in Article 4 of Chapter 1 of Title 32.1 a section numbered 32.1-92.1 and section numbered 32.1-92.2 that provides state funds for certain abortions. The General Assembly limited the access to such funding to women who otherwise meet the financial eligibility criteria of the State medical Assistance Program (Medicaid); and, who report the incident of rape or incest to a law enforcement or public health agency; or where there is evidence that the fetus will be born with a gross and totally incapacitating mental deficiency.

III. **Applicability:** The organizational levels responsible for action to comply with this policy are local health departments, local health districts, the Division of Women's and Infants' Health, and the Virginia Medical Assistance Program.

IV. **References**

A. Section 32.1-92.1 and section 32.1-92.2, Code of Virginia (1950) as amended
B. Policy and Procedure Instructions (PPI) 4.09 and 4.10 of July 1, 1982

V. **Policy:** Policy and Procedure Instructions (PPI) 4.09 and 4.10 of July 1, 1982 are hereby superseded. All applications for funding of abortions under the provisions of reference (A) shall be submitted and processed in accordance with the procedures and criteria promulgated in the attachment to this Instruction.

INFORMATION CHECKLIST TO ASSIST IN THE DETERMINATION OF FINANCIAL ELIGIBILITY

To quickly process your application, please provide the following:

1. A list of all people living with you. Include their age and relationship to you.

2. Have paystubs, letters from employers or other documents which will show what each person living with you earns when you return for the eligibility interview.

3. Have any documents that will show what pensions, annuities, grants-in-aid, dividends and/or interest income are received by each person living with you.

4. Bring your latest bank statements and/or bank books which document your bank accounts.

5. Verification of Life Insurance policies – life insurance policy, etc.

6. A statement of any cash on hand.

7. Verification of the value of automobile(s) – tax records, loan records, etc.

8. Verification of other personal property (except personal effects, household furnishings), a statement of the type and value of personal property owned and, if possible a statement from someone with knowledge of that type of property. For example, a stockbroker could verify the value of stocks and bonds.

9. Real Property – a statement of any real property owned other than your home and lot. Verification of this property must be provided. Verification could be provided by tax records or the statement of the Commissioner of Revenue of the locality.

DIVISION OF WOMEN'S AND INFANTS' HEALTH
CRITERIA AND APPLICATION OF PROCEDURES FOR STATE FUNDING OF CERTAIN ABORTIONS

I. BASIC REQUIREMENTS

A. The applicant shall be a resident of the Commonwealth of Virginia.

B. The applicant will meet the financial eligibility criteria of the Virginia State Medical Assistance Plan.

C. The applicant shall have reported the incident of rape or incest to a law enforcement or public health agency. A "public health agency" as used herein shall be defined as a local health department in the Commonwealth of Virginia. According to Virginia law, all physicians must report cases of alleged sexual assault of children under eighteen to the Child Abuse Hotline of the local Department of Social Services; or

D. The applicant's physician shall have performed appropriate tests and certifies that he believes that the fetus would be born with a gross and totally incapacitating physical deformity or a totally incapacitating mental deficiency.

II. THE APPLICATION PROCESS

A. The individual shall make application for funds for an abortion under this program to the local health department in her area of residence. The Application Form attached shall be used for this purpose.

B. The district health director or his/her designated representative shall take the following actions to obtain the financial eligibility determination:

1. Those applicants who are currently enrolled in the Medicaid Program shall be considered eligible for this Program. No further financial eligibility interviews are required.

2. If Item (1) above is not applicable, then contact the Department of Social Services (DSS) Medicaid eligibility worker responsible for applications serving the county health department where the application is made, by telephone, to schedule the financial eligibility determination interview. The appointment shall be made before the applicant leaves the health department.

3. The applicant will be furnished with an "Information Checklist to Assist in Determination of Financial Eligibility" (Attached) with verbal instructions that she be prepared to provide this information to the social service worker conducting the financial eligibility interview.

4. Be prepared to provide the Department of Social Services with any factors or conditions that are germane to the application, as well as the latest date that a first trimester abortion can be performed.

C. The Department of Social Services will take the following actions:

1. Will schedule the financial eligibility interview through the appropriate Social Services Office.

2. Will cause a social service worker from the Office to travel to the local health department in order to conduct the financial eligibility interview at the time and date scheduled.

3. Will cause the social service worker to provide the district director with the completed financial eligibility forms, if the applicant has provided the appropriate verification documents at the time of interview.

III. THE APPROVAL PROCESS

A. The district health director shall ensure that the appropriate application form is complete.

B. The district health director shall cause two photocopies of the application to be made. The director shall indicate his approval for payment by signing all copies of the application form in the space provided.

C. The approved application forms shall be distributed as follows:

1. The original shall be given to the applicant. This copy must be given to the facility performing the procedure.

2. One copy, along with a copy of the financial eligibility forms or a photocopy of the applicant's Medicaid card, shall be forwarded to Virginia Department of Health, Division of Women's and Infants' Health.

3. One copy shall be retained at the local health department.

IV. THE PAYMENT PROCESS

A. The facility performing the abortion shall submit the bill directly to the Division of Women's and Infants' Health for payment. **THE ORIGINAL APPROVED APPLICATION FORM MUST BE ATTACHED TO THE BILL.**

B. Payment shall be limited to the Medicaid allowance for the procedure. The "Year-end Cost Settlement" process currently used by the Virginia Medical Assistance Program shall **NOT** apply to this program. Year-end Cost Settlements are **NOT** authorized.

APPLICATION FOR STATE FUNDS FOR ABORTION
UNDER SECTION 32.1-92.1
CODE OF VIRGINIA (1950), AS AMENDED

CASE NO. _____ **DATE OF APPLICATION:**
_____

NAME OF APPLICANT:
_____

ADDRESS: _____ **NAME AND ADDRESS OF FACILITY TO**

PERFORM THE PROCEDURE:

_____
_____

_____
_____

_____

DATE OF BIRTH: _____

"I hereby request State funds under the provisions of Section 32.1-92.1 of the Code of Virginia (1950), as amended. I certify that this pregnancy is the direct result of:

RAPE _____ **INCEST _____**

DATE OF OCCURRENCE: _____ **DATE OF OCCURRENCE:**
_____

REPORTED TO: _____ **REPORTED TO:**
_____

_____
_____

ADDRESS: _____ **ADDRESS:**
_____

_____
_____

DATE REPORTED: _____ **DATE REPORTED:**
_____

_____ **_____** **_____**
(DATE) **(PARENT'S SIGNATURE, IF APPLICANT IS UNEMANCIPATED MINOR)** **(APPLICANT'S SIGNATURE)**

"I certify that my examination of the applicant and/or her official clinic record indicates that she is _____ weeks pregnant as of _____."
(DATE)

_____ _____

(DATE) (ATTENDING PHYSICIAN)

APPROVAL: "The Virginia Department of Health guarantees payment to the facility named in the application for performing an abortion on the individual named herein as the 'Applicant'. Such payment shall be limited to the usual reimbursement rate established by the Virginia Medical Assistance Program (Medicaid), and shall constitute full and final payment for such services."

_____ _____

(DATE) (DISTRICT HEALTH DIRECTOR)

Mail to: **Virginia Department of Health**
Division of Women's & Infants' Health
P. O. Box 2448, Room 135
Richmond, Virginia 23218

APPLICATION FOR STATE FUNDS FOR ABORTION
UNDER SECTION 32.1-92.2
CODE OF VIRGINIA (1950) AS AMENDED

CASE NO: _____ DATE OF APPLICATION: _____

NAME OF APPLICANT: _____ DATE OF BIRTH: _____

ADDRESS OF APPLICANT NAME, ADDRESS OF FACILITY PERFORMING PROCEDURE

_____
_____

_____
_____

_____
_____

WEEKS GESTATION: _____ GRAVIDA: _____ PARA: _____ AB: _____

PREVIOUS CHILDREN, LIVING OR DEAD, WITH INCAPACITATING PHYSICAL DEFORMITIES OR MENTAL DEFICIENCY: YES _____ NO _____

DATA THAT SUBSTANTIATES CERTIFICATION

TEST: _____ SUMMARY OF RESULTS: _____

TEST: _____ SUMMARY OF RESULTS: _____

TEST: _____ SUMMARY OF RESULTS: _____

PHYSICIAN CERTIFICATION

"I hereby certify that based on appropriate testing and my best medical judgement, the applicant will deliver a fetus with a gross and totally incapacitating physical deformity or a gross and totally incapacitating mental deficiency. That incapacitating condition is _____."

_____ _____
(DATE) (SIGNATURE OF PHYSICIAN)

"I hereby request State funds under the provisions of Section 32.1-92.2 of the Code of Virginia (1950) as amended."

_____ _____
(DATE) (SIGNATURE OF APPLICANT)

APPROVAL: "The Virginia Department of Health guarantees payment to the facility named in this application for performing an abortion on the individual named herein as the 'Applicant'. Such payment shall be limited to the usual reimbursement rate established by the Virginia Medical Assistance Program (Medicaid), and shall constitute full and final payment for such services."

_____ _____
(DATE) (DISTRICT HEALTH DIRECTOR)

Mail to: Virginia Department of Health
Division of Women's & Infants' Health
P. O. Box 2448, Room 135
Richmond, Virginia 23218